WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services

Community Integration Program II
Community Relocation Initiative
Questions and Answers

March 2006

Table of Contents

CIP II Community Relocation Initiative Questions and Answers

This document provides responses to frequently asked questions related to the implementation of the CIP II Community Relocation (CIP II-CR) initiative.

- Please refer to DDES numbered memo 2005-17, dated September 30, 2005, for program policies.
- Please use DDE-2678 to submit estimates.
- Questions are clustered by topic and listed alphabetically by topic.

Appeal Rights

If an estimate for the Community Relocation Initiative is submitted to the Bureau of Long-Term Support (BLTS) and the BLTS denies the cost as excessive, does the person have a right to appeal the decision?

Answer: It is important to remember that there are two processes:

a. determination of a person's waiver eligibility – which is able to be appealed (see Waiver Manual)
b. determination of funding availability – which the person may appeal, however the Division of Hearings and Appeals may find that they do not have jurisdiction.

Any applicant can appeal his/her denial of waiver eligibility as described in the Waiver Manual. The lack of CIP II-CR funding is similar to lack of funding at the county level when people have to be put on a waiting list.

The Bureau will inform the county that CIP II-CR funding is either "not available at this time" because there is not sufficient funding available for this person's costs, or, that the person's community costs are so high that CIP II-CR funding will not be possible. In either situation, the county can serve the person with its regular COP-Waiver or CIP II allocation when the person comes to the top of the county waiting list.

Assessments and Care Plans

1. *Can case management be the only service provided?*

   Answer: Yes, to assist with the case management of Medicaid card services that are long term care related.

2. *Does a care manager ask about divestment as part of the assessment?*

   Answer: Typically the county economic support/income maintenance worker who determines the nursing home Medicaid eligibility will ask about divestment. Since there may have been financial changes in the interim, such as the home being sold and those assets divested, it may be wise to ask again. Also, financial eligibility is required to be determined annually. Partner with your economic support/income maintenance staff on this question.

3. *I understand that a county can bill start up costs (assessment and plan costs) to the waiver, provided the costs are billed to the waiver after the person relocates. What if something happens and the relocation fails? Does the county eat the cost of the assessment and plan?*

   Answer: Assessment and plan costs incurred while the person was in the nursing home can be billed to the waiver after the person relocates. See Waiver Manual, page IV-27, SPC 604 Care Management. If, after the assessment and plan have been completed, the person does not relocate, the completed COP assessment and plan can be billed to the county's allocation for COP assessments and plans. If these allocations have been fully expended, then costs may be covered by the administrative allowance. Targeted case management cannot be billed while a person is in an institution.

CARS

Which CARS profile will this funding be reported on?

Answer: Waiver expenses associated with CIP II-CR participants are to be reported on CARS profile 368. This profile will allocate to 369 (non-federal portion of expenses) and 370 (federal portion of expenses). All federal funds will be paid. If the non-federal portion of the expenses exceed the non-federal contract, expenses in excess of the contract limit will roll to the county BCA (basic county allocation – profile 561).

Community Based Residential Facility (CBRF)

1. *What is the effect of the CIP II Community Relocation Initiative on a county's Community Based Residential Facility (CBRF) Cap?*

   Answer: Counties are required to set a limit on the amount of their COP, COP-W and CIP II allocation that they will use in CBRFs. This policy enables counties to make local decisions about the extent to which these limited funds may be used for alternative residential care. Using funds from a home care program for out of home care must be done deliberately and equitably to advance the goals of the program for participants.

   When a person is relocated to a CBRF from a nursing home, the cost of that individual's care plan will be figured into the CBRF cap. If there is concern that this relocation initiative will cause the county to exceed its local CBRF cap, consider the following:

   a. The long-term support planning committee can raise or lower the CBRF limit each year. It is a county-established maximum. As you are considering the county's cap you may wish to consider the effects of the relocation initiative on the need for additional funding for CBRF services.

   b. The county could establish a local policy creating a "working" percentage but allowing that percentage to be exceeded under certain or unanticipated circumstances up to a specified higher percentage. This higher percentage is what would be reported to the Department of Health and Family Services (DHFS). This gives the county some room to

respond to problems that are unforeseen, like a closing nursing home, or to accommodate relocations.

c. When the DHFS reviews the county set maximums, we do so against dollars actually spent each year for people who reside in CBRFs. If projected expenditures exceed the proposed county cap, we will ask the county to describe (in the annual COP Plan Update) its plan for progressing toward its goal, including timeframes. We will look for patterns of inappropriate use of funds and will do what we can to provide guidance to counties who are struggling with maintaining the home-care intent of the program.

d. The five conditions for CBRF placement are required for all individuals that are considering relocating to a CBRF. These conditions ensure that home-care and residential options are explored and discussed with the individual, that the person prefers a CBRF over other settings, that it is cost effective, and a quality setting. Variances are required if the CBRF under consideration is larger than 20 beds.

2. *Will CBRF expenses for individuals receiving CIP II-CR funding be included in the current monthly CBRF report sent to counties?*

   Answer: CIP II-CR funds are a separate funding stream and a new Long-Term Care code on Human Service Reporting System (HSRS) (Field 26, Code N), so they will not be incorporated into the current report. A new report for only CIP II-CR funded persons is being developed that will mirror the current report. However, to determine the county's percent of spending relative to its CBRF cap, you will need to combine the report totals. Because CR funding is a part of CIP II, the CBRF cap applies to that money as well.

3. *Will an assisted living facility refusing to accept Medicaid continue to be able to refuse?*

   Answer: Yes. The current COP-W/CIP II program policies apply. Counties also can refuse to contract with a facility that will not comply with contracting, fiscal or other program requirements, which may mean persons relocating may need to choose a facility willing to comply.

CIP II "Regular" vs. CIP II Community Relocation

1. *At what point in time does the CIP II-CR funding roll into the county CIP II base?*

   Answer: Funding supporting a relocated person who has been on the program for 180 days or more will become part of the county's CIP II-CR funding. Beginning with the calendar year contract following the end of the biennium (two year state budgeting period from 7/1/2005 through 6/30/2007), any CIP II-CR money gets combined with the regular CIP II. For example, relocation funding as of 6/30/07 (end of biennium) would be added to the 2008 CIP II regular contract allocation. This is the current thinking, but it could change.

2. *If a person relocates in May 2007 and receives CIP II-CR funding, will the person's cost roll into the county's CIP II allocation in July 2007?*

Answer: No, January 2008, the next contract year.

3. *How will the CIP II-CR funding affect a county's CIP II average?*

   Answer: When CIP II-CR funding rolls into regular CIP II funding beginning in contract year 2008, counties will be able to average all of their CIP II per diems and spend out their contract. If this CIP II average exceeds the CIP II per diem (currently $41.86), an approved variance is **not** required unless a county's combined CIP II and COP-W average exceeds the CIP II average. See also DDES numbered memo 2006-03, February 25, 2006.

4. *In "regular" CIP II funding as long as the average daily rate for all clients is $41.86 a day or less, the county receives full funding. If the county has only one client receiving the CIP II-CR funding with an initial care plan of $73.99 per day, will we only receive the $73.99 per day or will the person be included in the "regular" CIP II funding and be averaged with them?*

   Answer: The county will receive the relocation funding, $73.99 in this example, which in 2008 will be combined with the regular CIP II allocation. See answer to question 3 above. Prior to 2008, there can be no combining of CIP II and the CIP II-CR funding for an individual.

5. *Can a county use the CIP II-CR funding for other more expensive individuals in the COP-W and switch them into the CIP II-CR funding?*

   Answer: No. Once a person is on CIP II-CR, he/she must stay on that funding (no switching) until 2008. In 2008 when a county's CIP II-CR funding is combined with regular CIP II, then it will be possible to switch people.

COP "only" Funding

Is there one time COP funding available for relocation costs?

Answer: Yes and No. Yes, there is limited one-time COP funding available for those items a person may need in order to relocate that are not covered by Medicaid or the Medicaid waiver. Also, this one time funding could be made available to help the person with room and board for the first 2 to 3 months, while the person applies for and receives SSI in the community.

No, there is not ongoing COP for room and board or for other non-waiver allowable costs. Remember that using 100% COP funds requires a six month Wisconsin residency.

Diversions

A client has been relocated through the CIP II Community Relocation Initiative and resides in the community for 200 days. He passes away. His approved care plan per diem was $75 per day. However, his actual costs were $50 per day. How much does the county have available for a new diversion person, $75 or $50 per day?

Answer: The county has available to use, for diversions that meet high risk criteria, the amount approved for the relocated person. In this example that would be $75.

Eligibility

1. *What are the requirements for a person to be eligible for the CIP II-CR funding?*

   Answer: Participation in this relocation initiative is strictly voluntary for individuals living in nursing homes. Refer to DDES memo series 2005-17. To be eligible for this relocation funding the person must be a nursing home resident who meets the following criteria:
   - Person's nursing home care must be funded by Wisconsin Medicaid.
   - Person must have long-term care needs that will last more than one year or have a terminal illness.
   - Person is eligible for the CIP II home and community-based waiver, both functionally and financially.
   - Person must need waiver-funded long-term care services in order to relocate.

2. *May persons with mental health needs access this funding?*

   Answer: Yes, as long as the person is in a waiver allowable target group (frail elder or physical disability), meets a waiver level of care on the LTC functional screen and is eligible for COP-W/CIP II. In addition, Medicaid must be paying for nursing home costs in a nursing facility that is not in an Institution for Mental Disease (IMD).

Estimates

1. *If a person's plan is more expensive than the person's nursing homes costs, will the person be served under the CIP II-CR Initiative?*

   Answer: Maybe. The person could be served if sufficient savings have been generated by others who relocated with less costly community care costs.

2. *BLTS has a "pending list" of estimates that have been submitted. What does this list mean?*

   Answer: The pending list is comprised of people whose projected Medicaid community care costs are considerably higher than their nursing home costs. These individuals will have to wait for savings generated from other relocations. The county may be able to serve the individual by using funding from the county's COP-W/CIP II allocation.

Estimate Form

What are the guidelines for filling out the Estimate Form?

Answer: See Attachment 1.

Funding

1. *What care plan amount is considered to be available after the 180 days? The original per diem or what actually is being spent?*

   Answer: If the relocated person leaves the program after 180 days, the county continues to get the original per-diem to be used for a diversion determined to be at high risk of entering a nursing home (in accordance with criteria in DDES numbered memo issued April 2006).

2. *Can this CIP II-CR funding be used for Residential Care Apartment Complex (RCAC) services?*

   Answer: Yes. Remember that COP-Regular cannot be used in RCACs.

3. *A person who is receiving CIP II-CR funding goes to a nursing home and is not expected to return home. The person does well and is able to return home. Can the county access CIP II-CR again to relocate this person?*

   Answer: This will depend on the length of time the person is in the nursing home. The county should hold the episode open for 90 days per current policy to allow for the potential of a short term stay. However, if the county has held the episode open for the 90 days, closes it and then later the person seeks to relocate, the county can request CIP II-CR funding again.

4. *Will the county receive a letter or contract amendment when a relocated person terminates before 180 days?*

   Answer: Yes, but to minimize paperwork, such changes will occur no more often than quarterly.

Human Service Reporting System

1. *How do we code these relocations?*

   Answer: Counties must report costs on HSRS for Community Relocation participants using the new Long Term Care code "N" (field 26) and enter an "N" under type of movement (field 13). See also CARS for CARS profile reporting.

   If the relocated individual leaves the program for whatever reason after 180 days, the county may access this person's funding for a person on the waiting list who meets the special CIP II-CR high risk criteria. When this situation occurs, the county will enter the high risk

person's expenses on HSRS using the long term support code "N" in field 26 and a "D" for field 13 – diversion.

2. *How will tracking on HSRS continue after this biennium? Will the person's HSRS code always remain with that person?*

   Answer: When the funding rolls over to CIP II base funding, counties will change the LTS code for individuals who relocated under this program. The new LTS code will be a "2" or a "3" (CIP II or COP-W, county's choice). DHFS will track by name in HSRS if needed. The person will retain the same episode number also. This will allow the department to see the history of services for the individual.

3. *How long does a person need to be in a nursing home before the person should be closed on HSRS?*

   Answer: Current COP-W/CIP II procedures apply. The person's Standard Program Catagories' (SPC) should be closed after 30 days. The county may hold the funding for the individual for up to 90 days (180 days with approval from the Department). The county will not be able to receive CIP II-CR funding a second time for an individual if the county does not hold the initial CIP II-CR funding for at least 90 days. The Department can hold the funding in the same way.

4. *Will counties need to track participants of this initiative separately?*

   Answer: Both expenses and HSRS reporting must be tracked and reported separately.

Level of Care

I cannot process an estimate because the nursing home has not received a level of care (LOC) for the person. What can be done?

Answer: Contact the Bureau of Quality Assurance regional office and ask for the status.

Medicaid Personal Care and CIP II Community Relocation Funding

*How should the estimate form be completed if the care manager has not yet determined how much care will be Medicaid Personal Care (*MA PC*) and how much will be supportive home care or the residential cost?*

Answer: Fill in the form with your best estimate. Estimate the number of hours and cost. The cost comparison compares Medicaid nursing home and other card costs to community waiver and card costs. At this stage, it would not matter whether the costs are MA PC or waiver. However, by the time the final plan is submitted, these costs need to be clearly delineated in the Individual Service Plan (ISP). The award letter is based on the waiver costs in the ISP.

Medicare

Will Medicare Part D have an impact on the Community Relocation Initiative?

Answer: The new Medicare drug coverage should have little effect on the Community Relocation Initiative because drugs costs will be affected equally in the nursing home and in the community.

Moves

Some individuals are in a nursing home in one county but want to move to another county when they relocate, sometimes to be closer to family.

1. *What should happen if a nursing home resident is interested in relocating to the community, however, the community of choice is in a different county than the nursing home? For example: Mr. Ed wants to leave a nursing home in county A and live in the same city as his son who lives in county B.*

   Answer: The county that is first contacted by Mr. Ed and/or his relative should call the other county involved. Between the two counties, they can decide who will complete the assessment and care plan and bill the cost to the COP in the event that the person does not relocate and billing it to transitional care management might not be possible.

   Next the counties will need to decide who would be providing the ongoing care management services, which will involve implementing the care plan, securing services, establishing contracts, and making the move a reality.

   CIP II-CR funding will be allocated to the county who implements and monitors the care plan. (Usually that will be the county where the individual will physically reside after the move from the nursing facility.)

2. *What if neither county has COP assessment or plan funding?*

   Answer: For those individuals relocated, counties may bill the cost of the assessment and care plan to the waiver. These costs as well as the transitional case management should be coded on HSRS as 604.04. Additionally, counties should enter on HSRS an assessment and plan date to COP (LTS code 7). No costs should be entered – however, a county should enter the units.

   For those individuals who do not relocate, but for whom the county has conducted an assessment and plan, the cost may be charged to the COP assessment and plan allocations. If these funds have been expended, costs are allowed as administration costs for COP.

3. *What if the individual is under a protective placement completed by the county where the nursing home is located?*

Answer: The county that completed the protective placement will need to take responsibility for the "least restrictive placement," will implement the relocation and will receive the relocation funding. An interagency agreement, as in other similar situations, could include contracting with the placement county or another qualified agency for the ongoing care management.

4. *What are the procedures for moves between Waiver Counties and Family Care Counties*

   Answer: The procedures will vary depending on whether the person is a Family Care enrollee and how long the person has been an enrollee. A detailed discussion of the various scenarios is provided in Attachment 2.

Nursing Homes

Will a nursing home be able to hold the bed for a person who relocates under the program?

Answer: No, CIP II-CR funding cannot be used while the person is still technically the resident of a nursing home, as is the case with a Medicaid-funded bed hold. However, if the nursing home determined that the visit to the community met the requirements for Medicaid-funded therapeutic leave, a county agency could fund the therapeutic visit using COP. Medicaid-funded therapeutic and therapeutic/rehabilitative leave must meet the requirements of the Wisconsin Medicaid program and the Bureau of Quality Assurance.

Out-of-State Nursing Home

1. *May a person on a Wisconsin county waiting list who resides in an out-of-state nursing home access the CIP II-CR funding?*

   Answer: The person may not access the CIP II-CR funding unless the Wisconsin Medicaid data system indicates that Wisconsin Medicaid is paying for that person's care in that out-of-state nursing home.

2. *A person is protectively placed by Minnesota in a nursing home in Wisconsin and wants to return to community living in Minnesota under protective placement, Can this person use the CIP II-CR funding to move to Minnesota?*

   Answer: Any change in placement should occur in accordance with Minnesota laws and needs to be addressed by the Minnesota Medicaid program.

Quality Assurance

1. *What is the process to assure that persons who relocate will be well cared for?*

   Answer: The person's care manager and the county's program have the primary responsibility and fulfill that responsibility by having monthly contacts with the participant

and/or providers, quarterly face-to-face contact with the participant to assess the adequacy of services and providers, identifying changing needs, and making necessary changes in the plan of care. In addition, the state implements a quality assurance monitoring process, hears complaints, remedies/resolves problems that arise. Special follow-up will occur with participants at the required 30 and 90 day intervals and with people (or their families) who have left the program to ascertain why.

2. *How will the state follow along and determine if this program is effective?*

   Answer: The program's effectiveness will be judged based on:
   - Number of people who were able to choose community living.
     (Sample question: Did 1440 people relocate?)
   - Whether the state saved money while serving the people in the community.
     (Sample question: Are the costs, on average, of serving these 1440 people less in the community than if they remained in the nursing home?)
   - Whether people living in the community are safe and whether their care needs are being met.
     (Sample question: Are the results of quality assurance monitoring reports different for relocations than for other waiver participants?)
   - Whether people report that they are satisfied with their living arrangement and care.
     (Sample question: Are the results of the participant satisfaction survey different for relocations than for other waiver participants?)

Residency

How is residency determined for persons living in nursing homes?

Answer: The county of residence for a person living in a nursing home is the county in which the nursing home is located. However, if the person has been protectively placed in a nursing home, the person's county of residence is the county that originated the protective placement.

Room and Board

Is there ongoing COP funding available at the State level for individuals who do not have enough income to support their room and board expenses in a substitute living arrangement?

Answer: No. There was no increase in COP in the budget so counties will have to use existing allocations or arrange for services in locations that will not need additional COP.

Service Plan Approval

Should the county wait for the final approval of the service plan packet by both The Management Group (TMG) and BLTS before the person may relocate?

Answer: Yes. It is advisable to wait until the service plan is fully approved. Approval of the estimate amount is not the final approval for the funding or for program eligibility. If the person moves before the service plan is fully approved, funding could be jeopardized if the person is found not eligible or the person's proposed care plan is determined to be unsafe.

Service Plan Cost Decrease or Increase

1. *What is the process to inform BLTS of decreases in service plan costs after services have begun?*

   Answer: Counties do not need to inform BLTS when the care plan costs decrease after services have begun. Counties should either use that money for others who relocated under the initiative whose care plan costs increase or not use it. BLTS will be monitoring HSRS expenses reported and the individual's Medicaid card costs to ensure that the initiative's fiscal projections are met.

2. *What is the process to inform BLTS of increases in service plan costs after services have begun?*

   Answer: There is no need to inform BLTS. Counties are encouraged to manage these increases within existing CIP II-CR funds. Additional community relocation funding will not be made available for provider rate increases. However, if the person has a substantial change in their care needs and the county does not have any available CIP II-CR funding, the Department may be able to provide additional CIP II-CR funding if there are available uncommitted savings from other relocations. To inquire, contact Lisa Kelly at (608) 267-3659.

3. *Is there a dollar limit, over the final plan per diem, when the county needs to inform BLTS?*

   Answer: No, because the county will not be getting additional funds. See question #2 above for clarification.

4. *The county has been notified that the rate for a CBRF will be increasing the first of the year. Will the CIP II-CR Initiative provide added reimbursement to the county for those individuals in this CBRF who are funded by the CIP II-CR Initiative?*

   Answer: No

5. *Do "increases" include cost of living increases for staff wages?*

   Answer: The Department will not make CIP II-CR funding available for this purpose. However, the county may use any available CIP II-CR funding.

Start Date

How is the start date determined for nursing home relocations?

Answer: The start date for relocations is determined the same way as any other person applying for waiver funding. The effective date of eligibility (or start date) is the date a new applicant becomes eligible for COP-W/CIP II funding. It is the first day services may be billed to the waiver program.

The service plan packet is reviewed for four conditions to determine the effective date. The effective date is the first date upon which all four of the following conditions are met:

- The date the individual meets all the criteria to be eligible for Medicaid.
- The date the initial service plan is developed with the participant. This can be the date the care manager first started to discuss a plan of care with the participant, which may be earlier than the date the ISP was typed or signed.
- The date listed as the Screen Completion Date on the Long Term Care Functional Screen (completed by a certified screener).
- The date the individual first resides in a waiver allowable setting.

Start Up Costs

1. *How can we bill start up costs while the person is in the nursing home but we are setting up the residence?*

   Answer: See the Medicaid Waivers Manual, Relocation Related Services, SPC 106.01 and 106.03 starting on page IV-98. Also, review housing assistance for rent, SPC 106.02.

2. *The nursing home resident I am working with intends to move to an apartment. He has no belongings. The CIP II-CR estimate has been approved and included a listing of start up costs. As the person moves and the listed start up costs are incurred, how do they get paid?*

   Answer: Once the person's service plan has been approved by TMG and the final BLTS funding approval letter has been completed, effective the day the person leaves the nursing home you may bill on HSRS for reimbursement for these items. For those items that are covered by CIP II-CR funding, you bill CIP II. If you have requested one time COP relocation funding for COP eligible items and BLTS has approved funding for these, you bill COP for these items. See HSRS for coding information.

3. *How can a county access relocation start up funds that are not covered under Medicaid, Medicare or CIP II?*

   Answer: Review SPC codes 106.03 (Housing Start Up) and SPC code 112.56 (Housing Modifications) in the Waiver manual to verify that the items in question cannot by funded using CIP II. Include an itemized list in the service plan packet along with justification or explanation that neither Medicaid nor Medicare will fund the item. If approved, the amount

for the items that are not covered by other fund sources will be included in the BLTS funding approval letter as COP one time relocation funds.

Transportation

How is transportation paid for a person to visit a relocation site if the person decides to remain in the nursing home?

Answer: The care manager can collaborate with the nursing home discharge planner who may be able to provide the transportation as part of discharge planning. Families may be able to help. Contact the county's aging office or regional Independent Living Center to ask for available transportation or volunteers.

Traumatic Brain Injury (TBI)

Is a person residing in a Traumatic Brain Injury (TBI) Unit able to access this funding to relocate from the TBI unit into the community?

Answer: Contact Denise Cox in the Developmental Disabilities Services Section in the Bureau of Long Term Support to discuss getting this person on the Brain Injury Waiver waiting list. Her phone is 608-266-0547. The person must be on or in the process of being considered for the brain injury waiver waiting list before the person will be considered for CIP II-CR funding.

Depending on the circumstances and funding availability, the person may be eligible to access the Community Relocation funding. In these situations, you should call either Lisa Kelly at 608-267-3659 or Sharon Hron at 608-267-3660 to discuss what may be available. If the person is able to access the Community Relocation funding, the funding will be temporary until the person becomes able to access the Brain Injury Waiver as is currently the policy with regular CIP II funding.

Ventilator Dependent Unit in a Hospital Setting

Will a person who is residing in a ventilator dependent unit in a hospital be able to access this funding?

Answer: No. The person must reside in a nursing home.

Waiting List

1. *Does the applicant need to be on the county's LTS waiting list?*

   Answer: The person does not need to be on the county's wait list to be served. However, out of fairness to those in a nursing home and on the county's wait list, the county should make efforts to find out if those persons are interested and make plans for them first.

   A person won't be eligible unless their nursing home costs are being paid by Medicaid. A Medicaid nursing home cost history is needed for cost comparison calculations.

2. *The county's current waiting list policy addresses "at imminent risk of entering a nursing home." Should we modify the language?*

   Answer: It may be best to add language and specifically address when funding may be available for special purposes such as nursing home relocations.

3. *Can the county serve a person who is 7th on the waiting list and went to a nursing home?*

   Answer: Yes, if that is consistent with the county's wait list policy.

GUIDELINES FOR COMPLETING COMMUNITY RELOCATION INITIATIVE INITIAL CARE PLAN INFORMATION AND FUNDING ESTIMATE (DDE-2678)

Please type or use black ink so that forms are legible when faxed.

Name of Applicant, County Applying and Date of Birth: self-explanatory.

Medicaid Number: Forms must include the person's Medicaid number. Estimates cannot be approved until the person's Medicaid nursing home expenses are verified using the Medicaid number. Save time: do not submit the estimate form until you know the MA number.

Nursing Home Information (Name, status, date of admission): Please provide the name of the nursing home for tracking purposes. Indicate in the space provided whether or not the nursing home is closing or downsizing. It is helpful for data reporting purposes to know the date of admission. The date of admission should be when the person entered the nursing home regardless of funding source.

Date of Planned Relocation/Discharge: When completing this item, remember that the individual should not relocate until the care plan and funding have been approved by the Department. There are many factors that must be taken into account before all approvals are given.

If Nursing Home stay is less than 100 days, document why the stay is expected to be long term: The Department must ensure that the people being relocated would not have left the nursing home without the help of the Community Relocation Initiative. The care manager must complete this section if the stay will be under 100 days.

Proposed New Living Arrangement: Please indicate where the person will live. If the person will go to a residential setting, please provide the name if it is known when estimate is submitted.

Estimate of the person's Daily Waiver Cost: Daily waiver costs should include all ongoing costs that will be billed to CIP II, including care management. Do **not** include the following in this box: room and board, cost share, administrative costs, Medicaid card costs. Also, do **not** include one-time costs in the daily waiver total even if waiver allowable, instead report these costs under the "other" box.

Detail (Supportive Home Care, CBRF Service per diem, Transportation, Adult Day Care, Adaptive Aids, Home Modifications, Other): Please provide the estimated costs in each area. Use the "other" box for one-time costs. If more room is needed, write, "see attached sheet." This will enable these one-time costs to be factored in but not as ongoing costs.

Case management: Ongoing care management costs should be included in the daily waiver cost estimate. Please indicate that you have included care management; for example, waiver rate is "$70/day incl. $3 cm." Put one-time relocation related care management or assessment and plan costs in the "other" box.

Medicaid card costs: If you know the exact Medicaid card costs for the services that will be needed in the community, please indicate these dollar amounts on the estimate form, e.g., MA personal care. If you do not know the Medicaid card costs for the services that will be needed in the community, please indicate the amount of the service the person will need, such as hours/day, times/week, etc. BLTS will generate an estimate. You do not need to supply the costs for medications and physician services. BLTS will make assumptions about those based on history.

Substitute care room and board (CBRF, Adult Family Home (AFH)): Please supply the room and board costs for the substitute care setting; this amount is used to estimate the feasibility of the living arrangement. Please be aware, additional COP funds are not available to help cover room and board.

SSI and income: Indicate if the person will be on SSI and/or SSI-E in the community. If possible, please indicate what the person's income will be upon return to the community. If the community income cannot be obtained, please indicate what the person's income is in the nursing home setting and the source of that income.

One time start-up costs: Itemize those one time costs that will be covered by CIP II-CR and those one time costs for which the county is requesting one time COP regular relocation funding (a special allocation of exceptional expense funding set aside for this initiative). Attach a separate sheet if necessary.

Estimate of the nursing home costs: Some have asked if we can provide the rates of nursing homes or give counties an idea of what the person's costs are. The Medicaid allowable rates do not really reflect what that individual's costs are as there may be patient liability. The rates also do not include an individual's other card costs in the nursing home. These can vary considerably from person to person. Counties should provide the community care estimate based on a safe care plan. The Department will research the nursing home costs.

COMMUNITY RELOCATION INITIATIVE AND MOVES BETWEEN FAMILY CARE AND WAIVER COUNTIES

Scenario 1 - Person resides in a nursing home, is currently enrolled in Family Care (minimum of six months) and moves to the community in a Waiver County (no nursing home Medicaid expenses incurred)

- Person is placed on the receiving County's wait list.
- Family Care funds are used to fund the person until they come to the top of the wait list.

Scenario 2 - Person resides in a nursing home, is currently enrolled in Family Care (FC) (does not meet the six month requirement), and moves to the community in a Waiver County. (No nursing home Medicaid expenses incurred, but Department can use a nursing home cost average to do cost comparison.)

- Person is **not eligible** for Family Care Transition funding.
- Person **is eligible** for community relocation funds.
- Person counts as a waiver relocation.
- County of placement receives the CIP II-CR funding.
- Assessment and Plan is done by receiving County.
- FC care manager works collaboratively with receiving county care manager to assure smooth transition.

Scenario 3 - Person resides in a nursing home in a Family Care County – is not currently enrolled in Family Care and chooses to move to the community in a Waiver County. (Nursing home Medicaid expenses may have been incurred – no Family Care capitation payment in place.)

- Waiver County care manager notifies Family Care County of their intent to relocate the individual.
- Waiver County does the assessment and care plan.
- Waiver County receives CIP II-CR funding.
- Individual counts as a Waiver relocation.

Scenario 4 - Person resides in a nursing home in a Family Care County – is not currently enrolled in Family Care, chooses to move to a community in a Family Care County, and chooses to enroll in Family Care. (Medicaid expenses may have been incurred – no Family Care capitation payment involved until enrollment.)

- Resource Center determines eligibility and enrolls person in Family Care.
- Family Care counts individual as a nursing home relocation.

Scenario 5 - Person resides in nursing home in a waiver county and chooses to move to the community in a Family Care county.

- County of first contact (may be waiver county or may be Family Care county) alerts the other county of the person's intent to relocate.
- County of placement does assessment and plan.
- Person enrolls in Family Care (only other choice would be fee-for-service).
- No CIP II-CR funding is involved.

Scenario 6 - Person resides in a nursing home in a waiver county and chooses to move to the community in a different waiver county.

- County of first contact notifies the other county of the person's intent to relocate.
- County of placement does the assessment and plan.
- County of placement receives the CIP II-CR funding.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2678 (09/26/05)

COMMUNITY RELOCATION INITIATIVE
INITIAL CARE PLAN INFORMATION AND FUNDING ESTIMATE

Completion of this form is voluntary. If not completed, the request cannot be processed. The personally identifiable information is being collected to process program eligibility. Completed forms will only be accessed by staff processing the request.

Name – Applicant		County Applying
Date of Birth / /	Medicaid Number	Name of Nursing Home

Date of Admission to Nursing Home / /	Date of Planned Relocation/Discharge / /	Is the Nursing Home Closing or Downsizing? ☐ Yes ☐ No

If Nursing Home stay is less than 100 days, document why the stay is expected to be long term

Proposed New Living Arrangement	Estimate of the person's **daily waiver** cost (Do not include room and board or cost share.)

This cost **includes** the following estimated **daily** amounts:

Supportive Home Care	CBRF Service Per diem	Transportation
Adult Day Care	Adaptive Aids	Home Modification

Other

If this person chooses to move to a substitute care setting, what are the monthly room and board costs?

Estimate of the daily **Medicaid card** services person will need (hours/day; times/week; or dollar amount, if known):

MA Personal Care	Home Health (RN / Therapies)

Other Known, e.g., Transp., DME, DMS

Will this person receive **SSI** upon return to the community? ☐ Yes ☐ No

Will this person access the SSI Exceptional Expense (**SSI-E**) benefit? ☐ Yes ☐ No

Will **one time funding** be needed for start-up costs (not covered by CIP II)? ☐ Yes ☐ No

Explain cost and items	Amount of person's income

SIGNATURE – Care Manager	Name – Care Manager (**Print**)	Date Signed / /

Telephone Number	Fax Number	E-Mail Address

Fax completed form to Bureau of Long-Term Support/Community Relocation Initiative at 608-267-2913

For Bureau of Long-Term Support use

☐ Estimate not able to be approved—no Medicaid data available. BLTS will hold.

☐ Estimate not able to be approved at this time. BLTS will hold as pending.

☐ Estimate approved to proceed. Develop and submit waiver application packet to TMG.

Estimate approved by BLTS on: / /	Total Amount (waiver and MA card):	Estimate approval faxed to county on: / /